Plan Document and Summary Plan Description for

Company

Preventive Care Program (PCP)

This document (sometimes referred to as the SPD) describes the Preventive Care services offered to eligible employees of Company (the *employer* and *Plan Sponsor*) and their dependents. The Preventive Care Program (PCP) is a component of the Company Comprehensive Health and Welfare Plan.

IMPORTANT INFORMATION

Questions?	**For current and new-hire enrollment as well as benefit election confirmation. If *you* would like to change enrollment or to confirm the benefits *you* already elected, *you* should call your Benefits department, xxx-xxx-xxxx.** **Bay Bridge Administrators, the *Third Party Administrator*, will handle the payment of claims for your Preventive Care benefits. If you have questions on preventive claims you may call: 1-800-845-7519**
Telephone Numbers	**Company – xxx-xxx-xxxx** **Bay Bridge Administrators Claims - 800-845-7519** **PHCS/Multiplan to find a provider - 1-800-922-4362**
Website	**www.bbadmin.com for claim forms** **www.multiplan.com to find a provider**
Mailing Address	***Claims* and written inquiries should be mailed to:** **Customer Service Department** **Bay Bridge Administrators** **P.O. Box 161690 Austin, TX 78716**

TABLE OF CONTENTS

I. INTRODUCTION TO YOUR COVERAGE

The Preventive Care Program is designed to provide coverage for *Preventive Care* only and does not cover any expenses incurred for non-preventive services, including hospitalizations or expenses relating to an injury or sickness. The Preventive Care Program is designed to constitute "minimum essential coverage" as defined under Section 5000A of the U.S. Internal Revenue Code and thereby assist eligible employees in avoiding tax penalties under that section of the Internal Revenue Code.

Benefits under the Preventive Care Program are provided on a "self-insured" basis, which means that the funding for the benefits is paid from the general assets of *your employer* and contributions made by *covered employees*. *Your employer* has contracted with Bay Bridge Administrators (BBA), the *Third Party Administrator*, to provide *claim* processing, and other administrative services. BBA does not pay any benefits from its own assets, but processes and pays (or denies) claims under the Preventive Care Program.

Benefits under this *plan* shall be paid only if the *plan administrator* decides in its discretion that a *covered person* is entitled to them. The *Third Party Administrator* is not a fiduciary under the *plan* by virtue of paying claims in accordance with the *plan's* rules as established by the *plan administrator*.

Italicized words used in this document have special meanings and are defined at the back of this document.

The *third party administrator* issues identification (ID) cards containing important coverage information. Please verify the information on the ID card and notify Customer Service (contact information in the chart at the front to this document) if there are errors. *You* will be asked to present *your* ID card whenever *you* receive services from a *participating provider*.

You will find information regarding *participating providers* on the website listed in the chart at the beginning of this document or you may call 1 -800 -922 -4362 or visit www.multiplan.com for information.

Participating providers frequently change, and the website may not be entirely up to date. To be sure that the health care provider *you* are using is a *participating provider*, you will need to check by calling **Multiplan/PHCS Customer Service at 800-922-4362**.

NO BENEFITS WILL BE PAID UNDER THE PREVENTIVE CARE PROGRAM UNLESS SERVICES ARE PROVIDED BY A *PARTICIPATING PROVIDER*. Of course, using a *participating provider* does not guarantee that benefits will be paid under the Preventive Care Program. Other conditions explained in this document must also be met for the Preventive Care Program to pay benefit for a service.

II. ELIGIBILITY, ENROLLMENT AND *EFFECTIVE DATE*

A. Eligibility

You are eligible for the Preventive Care Program if *you* are:

1. Classified by your *employer* as a full-time employee regularly scheduled to work a minimum of xx hours per week.

An eligible employee who elects coverage under the Preventive Care Program may also elect coverage for his or her eligible dependents. An employee must enroll for coverage in order to enroll his/her eligible dependents. If both parents are covered as employees, a child who is an eligible dependent of both may be covered under the Preventive Care Program by either parent, but not both.

The Preventive Care Program is not available to any employee or dependent who is not a United States citizen or a permanent resident of the United States and works in the United States or its territories. Employees who work and reside in foreign countries are not eligible for the Preventive Care Program. Employees and dependents who are United States citizens or permanent residents of the United States working outside of the United States on a temporary basis are eligible for coverage under this *Plan*.

Eligible dependents include a *covered employee's*:

1. Lawful spouse became married in a certificated ceremony. This does not include any common law spouse regardless if recognized under state or country law, even if documents demonstrating governmental recognition of the marriage are provided.

2. Children, from birth through the last day of the month in which the child attains age 26, including the employee's:
   a. Natural (biological) child;
   b. Child who is legally adopted by or placed with *covered employee* for legal adoption from the earlier of the adoption date or the date of placement for adoption. Date of placement means the assumption and retention by the employee of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support;
   c. Stepchild;
   d. Child for whom *covered employee* is the legal guardian appointed by a court of law;

3. Dependent children who are disabled. Application for extended coverage and proof of incapacity must be furnished to the *plan administrator* within 31 calendar days after the dependent child reaches age 26. The *plan administrator* may ask for an independent medical exam to determine the functional capacity of the dependent child. After this initial proof, the *plan administrator* may request proof again each year. A dependent child may be eligible for coverage if coverage has not otherwise terminated under this *Plan* and if he/she meets all of the following criteria:

   a. Became disabled before age 26;
   b. Was a *covered dependent* under the *Plan* prior to reaching age 26;
   c. Is incapable of self-sustaining employment, because of a *physical disability*, developmental mental disability, mental illness, or mental health disorder that is

expected to be ongoing for a continuous period of at least two years from the date initial proof is supplied to the *Plan*;

d. Is dependent on *covered employee* for a majority of financial support and maintenance.

If the dependent child is disabled and 26 years of age or older at the time of the *covered employee's* enrollment in this Plan, the *covered employee* may enroll the dependent child if within 31 calendar days after the *covered employee's* initial enrollment in this *Plan the covered employee* provides the *Plan* with proof that such dependent child meets all of the following requirements:

a. Became disabled before age 26;
b. Received health coverage through the *covered employee* within the 60-day period immediately preceding the *covered employee's* enrollment for coverage under this Plan;
c. Is incapable of self-sustaining employment, because of a *physical disability*, developmental mental disability, mental illness, or mental health disorder that is expected to be ongoing for a continuous period of at least two years from the date initial proof is supplied to the *Plan*;
d. Is dependent on *covered employee* for a majority of financial support and maintenance.

B. Enrollment and *Effective Date*

New Enrollment: The eligible employee must make written application to enroll him/herself and any eligible dependents and pay any required *contribution*, within 31 calendar days of the date the employee first becomes eligible. Coverage will be effective on the first of the month following a xx-day waiting period.

Annual Enrollment: The employee may enroll him/herself and his/her eligible dependents during the *employer's* annual enrollment period. Coverage will be effective on the date indicated during the annual enrollment.

Rehire: A terminated or laid off Employee who is rehired will be treated as a new hire, with the exception of an Employee returning to work directly from COBRA coverage. This Employee does not have to satisfy the Employee Waiting Period or Pre-Existing Conditions provision.

Late Enrollment. Not allowed.

Special Enrollment Period for Employees and Dependents. If *you* are an eligible employee or an eligible dependent of an eligible employee but not enrolled for coverage under this *Plan*, *you* may enroll for coverage under the terms of this *Plan* if all of the following conditions are met:

1. *You* were covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The eligible employee stated in writing at the time of initial eligibility that coverage under a group health plan or health insurance coverage was the reason for declining

enrollment, but only if the *employer* required a statement at such time and provided the employee with notice of the requirement and the consequences of such requirement at the time;

3. *Your* coverage described in paragraph 1 above was:
   a. COBRA or state continuation provision coverage and the coverage under such provision terminated because it was exhausted; or
   b. Other coverage that terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or *employer contributions* toward such coverage were terminated; and

4. The eligible employee requested such enrollment not later than 31 calendar days after the date of exhaustion of coverage described in paragraph 3.a above, or termination of coverage or *employer contributions* described in paragraph 3.b above.

Coverage will be effective on the date of the event described in paragraph 3.a or 3.b above provided the Plan receives the application for coverage as required.

Special Enrollment Period for *Covered Persons* due to the Acquisition of New Dependents. New dependents may enroll if all the following conditions are met:

1. A group health plan makes coverage available to a dependent of an employee; and

2. The employee is eligible for coverage under this *Plan*; and

3. They become dependents of the employee through marriage, birth, adoption, placement for adoption, or legal guardianship. This *Plan* shall provide a dependent special enrollment period during which the person may be enrolled under this *Plan* as a dependent of the employee, and in the case of the birth, adoption, children placed for adoption, or the legal guardianship of a child, the employee may enroll and the spouse of the employee may be enrolled as a dependent of the employee if such spouse is otherwise eligible for coverage. The eligible employee, if not previously enrolled, is required to enroll when a dependent enrolls for coverage under this *Plan*. In the case of marriage, the employee, the spouse and any new dependents resulting from the marriage may be enrolled, if otherwise eligible for coverage; and

4. Application must be received within 31 calendar days of the date the employee first acquires the dependent and coverage will be effective on the date of the marriage, birth, adoption, placement for adoption, or legal guardianship as described in paragraph 3 above.

Notwithstanding paragraph 4 above, if a *covered employee* has a spouse and/or dependent child/children covered under this *Plan* and subsequently acquires an eligible dependent child through birth or adoption, the newly acquired dependent child will be considered covered under the *Plan* effective on the date of the birth or adoption, provided that the employee enrolls the newly acquired dependent child within 60 days of the birth or adoption.

Note: Other dependents (such as siblings of a newborn child) are not entitled to special enrollment rights upon the birth or adoption of a child.

Special Enrollment Period for Medicaid and Children's Health Insurance Program (CHIP) Participants. If an eligible employee and/or his/her eligible dependents are covered under a state Medicaid plan or a state CHIP and that coverage is terminated as a result of loss of eligibility, then the eligible employee may request enrollment in the *Plan* on behalf of him/herself and/or his/her eligible dependents. Such request must be made within 60 days of the date the employee's and/or his/her dependent's coverage is terminated from such state plans.

If an eligible employee and/or his/her eligible dependents become eligible for a premium-assistance subsidy under the *Plan* through a state Medicaid plan or a state CHIP (if applicable), then the eligible employee may request enrollment in the *Plan* on behalf of him/herself and/or his/her eligible dependents. Such request must be made within 60 days of the date the employee and/or his/her dependents are determined to be eligible for the subsidy under such state plans.

Coverage will be effective the date other coverage is terminated provided the *Plan* receives the application for coverage as required.

III. BENEFIT SCHEDULE

The Preventive Care Program is different from most health plans. It covers only a very limited and specific set of Preventive Care services. *Preventive Care* services include:

(1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);

(2) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;

(3) With respect to Covered Persons who are infants, children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) With respect to Covered Persons who are women, such additional Preventive Care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The benefits covered under the Preventive Care Program are limited exclusively to the items in the chart below. Even if a condition is identified through one of the items listed in the chart, the Preventive Care Program does not provide any benefits for treatment of that or any other condition, *sickness* or *injury*.

Items covered under the Preventive Care Program are not subject to any co-payments, deductibles or coinsurance. When benefits are payable under the terms of the Preventive Care Program, they are limited to the most cost effective and medically necessary alternative.

Remember, no benefits are available under the Preventive Care Program for services received from a provider who is not a participating provider, and you are responsible for verifying that the provider you are using is a participating provider. If you use a non-participating provider, you are responsible for all charges, including charges for items listed in the chart below.

BENEFITS	Member Responsibility	
	IN-NETWORK	OUT-OF-NETWORK
"Benefit Year" means a Calendar Year, which is the period of twelve (12) consecutive months commencing on January 1st and continuing through December 31st of that year		
Deductible (Per Benefit Year) Individual Deductible	$0	Out of Network Benefits Not Covered
Coinsurance	0% of covered expenses	Out of Network Benefits Not Covered
Out-of-Pocket Maximum (Per Benefit Year) The Out-of- Pocket Maximum includes Deductible, Coinsurance, and Co-payments.	$0	Out of Network Benefits Not Covered
Maximum Lifetime Benefits (while covered under the Preventive Care Services Only Plan)	Unlimited	Out of Network Benefits Not Covered

Covered Preventive Care Services

Covered Preventive Services for Adults	Member Responsibility	
	In-network	Out-of-network
Abdominal Aortic Aneurysm, Males Ages 65-75 Limitation / Frequency: Men who have ever smoked / 1 Per Lifetime	0%	Not Covered
Alcohol Misuse Screening Limitation / Frequency: Ages 11 and older, Pregnant Women / 1 per calendar year	0%	Not Covered
Alcohol Misuse Counseling Limitation / Frequency: Ages 11 and older, Pregnant Women / 1 per calendar year	0%	Not Covered

Covered Preventive Services for Adults	Member Responsibility	
	In-network	Out-of-network
Aspirin to Prevent of Cardiovascular Disease Limitation / Frequency: Males Ages 45-79, Women Ages 55-79, pregnant women after 12 weeks of gestation / Prescription required /30 day supply / 12 per calendar year	0%	Not Covered
Blood Pressure screening Limitation / Frequency: Generally performed in conjunction with Wellness Visit	0%	Not Covered
Cholesterol screening Limitation / Frequency: Men 35+, 20-35 w/risk for coronary heart disease: Women 45+, 20-45 w/risk of coronary heart disease / 1 per calendar year	0%	Not Covered
Colorectal Cancer screening- Fecal Occult Blood Testing Limitation / Frequency: Adults over age 50, Adults < age 50 with family hx of colorectal cancer / 1 per calendar year	0%	Not Covered
Colorectal Cancer Screening- Flexible Sigmoidoscopy Or Sigmoidoscopy Limitation / Frequency: Adults ages 50 - 75, Adults < age 50 with family hx of colorectal cancer / 1 every 5 years	0%	Not Covered
Depression Screening Limitation / Frequency: 1 per calendar year	0%	Not Covered
Diabetes Type 2 Screening Limitation / Frequency: Hx of high blood pressure / 2 per calendar year	0%	Not Covered
Diet Counseling Limitation / Frequency: 6 hours per calendar year / Adults at risk for chronic disease	0%	Not Covered
Hepatitis B Screening Limitation / Frequency: 1 per calendar year	0%	Not Covered
Hepatitis C Screening Limitation / Frequency: 1 per calendar year for adults at increased risk / 1 time screening adults born between 1945 and 1965	0%	Not Covered
HIV – Human Immunodeficiency Virus Screening Limitation / Frequency: Ages 15-65 and other ages at increased risk / 1 per calendar year	0%	Not Covered
Immunization Vaccines(Adult) Includes Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella	0%	Not Covered

Lung Cancer Screening Limitation / Frequency: Ages 55 - 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years / 1 per calendar year	0%	Not Covered
Covered Preventive Services for Adults	**Member Responsibility**	
	In-network	**Out-of-network**
Obesity Screening and counseling Limitation / Frequency: 1 per calendar year	0%	Not Covered
Sexually Transmitted Infection (STI) Prevention Counseling Limitation / Frequency: Adults and Adolescents > age 11 at higher risk / 1 per calendar year	0%	Not Covered
Syphilis Screening Limitation / Frequency: Adults at higher risk / 1 per calendar year	0%	Not Covered
Tobacco Use Screening Limitation / Frequency: Adults / 1 per calendar year	0%	Not Covered
Tobacco Use Cessation Intervention Limitation / Frequency: Tobacco users / 8 per calendar year	0%	Not Covered
Wellness Visits - Adults Limitation / Frequency: 1 per calendar year	0%	Not Covered
Covered Preventive Services for Women, Including Pregnant Women		
Anemia Screening Limitation / Frequency: Pregnant Woman / 1 per calendar year	0%	Not Covered
Breast Cancer Genetic Test Counseling (BRCA) For Women At Higher Risk Limitation / Frequency: 1 per lifetime	0%	Not Covered
Breast Cancer Genetic Testing For Women At Higher Risk Limitation / Frequency: 1 per lifetime	0%	Not Covered
Breast Cancer Screening Mammography Limitation / Frequency: 1 per calendar year / Women over Age 40	0%	Not Covered
Breast Cancer - Chemoprevention Counseling Limitation / Frequency: Women at Higher Risk / 1 per calendar year	0%	Not Covered
Breastfeeding Comprehensive Support and Counseling Limitation / Frequency: 3 per calendar year	0%	Not Covered
Breastfeeding Pump Limitation / Frequency: 1 per lifetime	0%	Not Covered

Breastfeeding Pump Supplies Limitation / Frequency: 2 each code	0%	Not Covered
Cervical Cancer Screening, Pap Smear Limitation / Frequency: 1 per calendar year/ Women 21 to 65	0%	Not Covered
Chlamydial Infection Screening Limitation / Frequency: 1 per calendar year	0%	Not Covered
Covered Preventive Services for Women, Including Pregnant Women	**Member Responsibility**	
	In-network	**Out-of-network**
Contraception: Sterilization Limitation / Frequency: 1 per lifetime	0%	Not Covered
Contraception: Sterilization Follow-Up Limitation / Frequency: 1 per lifetime	0%	Not Covered
Contraception: Cervical Cap/Diaphragm Limitation / Frequency: 1 per calendar year	0%	Not Covered
Contraception: Intrauterine and Implantable Devices Limitation / Frequency: 1 every 5 calendar years	0%	Not Covered
Contraceptive injection Limitation / Frequency: 4 per calendar year	0%	Not Covered
Contraceptive Patches/ Female Condoms Limitation / Frequency: 104 patches per calendar year	0%	Not Covered
Contraception: Oral Contraceptives Limitation / Frequency: 12, 30-day prescriptions per calendar year	0%	Not Covered
Domestic and Interpersonal Violence Screening and Counseling for all Women Limitation / Frequency: Screening Generally performed in conjunction with Wellness Visit / Counseling visit - 1 per calendar year	0%	Not Covered
Folic Acid Supplements Limitation / Frequency: 12 per calendar year / covered only with a valid doctor's prescription	0%	Not Covered
Gestational Diabetes Screening Limitation / Frequency: 1 per pregnancy	0%	Not Covered
Gonorrhea Screening Limitation / Frequency: for women at higher risk / 1 per calendar year	0%	Not Covered
Hepatitis B Screening Limitation / Frequency: For Pregnant Women at their first prenatal visit	0%	Not Covered
HIV Screening Limitation / Frequency: Sexually active women / 1 per calendar year	0%	Not Covered

Human Papillomavirus (HPV) DNA test Limitation / Frequency: 1 every 3 years / Women 30-65	0%	Not Covered
Prenatal Care Visits Limitation / Frequency: Pregnant Woman / Visit payable only if associated with covered preventive screening	0%	Not Covered
Osteoporosis Screening Limitation / Frequency: Age 60+ / 1 every 2 years	0%	Not Covered
Covered Preventive Services for Women, Including Pregnant Women	**Member Responsibility**	
	In-network	**Out-of-network**
Rh Incompatibility screening Limitation / Frequency: 1 screening per pregnancy and follow-up testing for women at higher risk	0%	Not Covered
Sexually Transmitted Infection (STI) Prevention Counseling Limitation / Frequency: Sexually active women / 1 per calendar year	0%	Not Covered
Syphilis Screening Limitation / Frequency: Pregnant Women / 1 per calendar year	0%	Not Covered
Tobacco Use Screening Limitation / Frequency: Pregnant Women / 1 per pregnancy	0%	Not Covered
Tobacco Use Cessation Intervention Limitation / Frequency: Pregnant Tobacco users / 8 per calendar year	0%	Not Covered
Urinary Tract Or Other Infection (Bacteriuria) Screening Limitation / Frequency: During pregnancy / 1 at 12 to 16 weeks' gestation (or 1st prenatal visit if later)	0%	Not Covered
Well-Woman Visits Limitation / Frequency: 1 per calendar year	0%	Not Covered
Covered Preventive Services for Children		
Alcohol and Drug Use Assessments Limitation / Frequency: Ages 11 and older / 1 per calendar year	0%	Not Covered
Alcohol and Drug Use Counseling Limitation / Frequency: Ages 11 and older / 1 per calendar year	0%	Not Covered
Autism Screening Limitation / Frequency: at 9, 18, 24 months, 3 and 4 years	0%	Not Covered

Behavioral Assessments Limitation / Frequency: Generally performed in conjunction with Wellness Visit / Refer to Well Child Visit Frequency for Age Group	0%	Not Covered
Blood Pressure Screening Limitation / Frequency: Generally performed in conjunction with Wellness Visit / Refer to Well Child Visit Frequency for Age Group	0%	Not Covered
Cervical Cancer Screening, Pap Smear Limitation / Frequency: Sexually active females / 1 per calendar year	0%	Not Covered
Covered Preventive Services for Children	**Member Responsibility**	
	In-network	**Out-of-network**
Depression Screening Limitation / Frequency: Adolescents 12-18 at higher risk / 1 per calendar year	0%	Not Covered
Developmental Screening Limitation / Frequency: Children under age 3 / Refer to Well Child Visit Frequency for Age Group	0%	Not Covered
Dyslipidemia Screening Limitation / Frequency: Generally performed in conjunction with Wellness Visit / Refer to Well Child Visit Frequency for Age Group	0%	Not Covered
Fluoride Varnish Limitation / Frequency: 6 months - 6 years (ends on 7th birthday / Total of 8 applications)	0%	Not Covered
Gonorrhea Prevention Medication Limitation / Frequency: Newborns / 1 per lifetime	0%	Not Covered
Hearing Screening Limitation / Frequency: Newborns and Development Screenings up to age 3	0%	Not Covered
Height, Weight, And Body Mass Index (BMI) Measurements For Children Limitation / Frequency: Generally performed in conjunction with Wellness Visit / Refer to Well Child Visit Frequency for Age Group	0%	Not Covered
Hematocrit or Hemoglobin Screening for all Children Limitation / Frequency: 1 per calendar year	0%	Not Covered
Hemoglobinopathies or Sickle Cell Screening Limitation / Frequency: 1 per lifetime / Newborn 0 - 90 days	0%	Not Covered
Hepatitis B Screening	0%	Not Covered

Limitation / Frequency: Adolescents at high risk / 1 per calendar year		
HIV Screening Limitation / Frequency: Adolescents at high risk / 1 per calendar year	0%	Not Covered
Hypothyroidism Screening Limitation / Frequency: 1 per lifetime / Newborn 0 - 90 days	0%	Not Covered
Immunizations Includes Diphtheria, Tetanus, Pertussis, Influenza, Haemophilus Influenza Type B, Measles, Mumps, Rubella, Hepatitis A, Meningococcal, Hepatitis B, Pneumococcal, Human Papillomavirus, Rotavirus, Inactived Poliovirus, Varicella	0%	Not Covered
Covered Preventive Services for Children	**Member Responsibility**	
	In-network	**Out-of-network**
Iron Supplements Limitation / Frequency: Ages 6 to 12 months at risk for anemia / 12 per calendar year / covered only with a valid doctor's prescription	0%	Not Covered
Lead Screening Limitation / Frequency: To age 7 / No frequency limit	0%	Not Covered
Medical History for all Children throughout Development Limitation / Frequency: Generally performed in conjunction with Wellness Visit / Refer to Well Child Visit Frequency for Age Group	0%	Not Covered
Obesity Screening and Counseling Limitation / Frequency: 1 per calendar year	0%	Not Covered
Oral Health Assessment for Young Children Limitation / Frequency: To age 10 / Refer to Well Child Visit Frequency for Age Group	0%	Not Covered
Phenylketonuria (PKU) (Metabolic/Hemoglobin) Screening Limitation / Frequency: Newborn (0 - 90 days) / 1 per lifetime	0%	Not Covered
Sexually Transmitted Infection (STI) Prevention Counseling Limitation / Frequency: Adolescents > age 11 at higher risk / 1 per calendar year	0%	Not Covered
Tuberculin Testing for Children at Higher Risk of Tuberculosis Limitation / Frequency: To age 17 / Refer to Well Child Visit Frequency for Age Group	0%	Not Covered
Vision screening Limitation / Frequency: 1 per calendar year up to age 21	0%	Not Covered
Well Child Visits: Newborn to 11 months Limitation / Frequency: 6 visits per calendar year	0%	Not Covered
Well Child Visits: Children ages 1 -4 Limitation / Frequency: 7 visits per calendar year	0%	Not Covered

Well Child Visits: Ages 5 – 17 Limitation / Frequency: 1 per calendar year	0%	Not Covered
There are age and other limitations on the Preventive Care services covered. For a more detailed list of covered Preventive Care services, please refer to the Preventive Care Benefits and Plan Exclusions sections of this document*. *You* may also refer to www.healthcare.gov/center/regulations/prevention.html*****, www.hrsa.gov/womensguidelines/* and www.hhs.gov/healthcare/facts/factsheets/2010/09/The-Affordable- Care-Act-and-Immunization.html*. You may contact the Plan Administrator at **xxx-xxx-xxxx** to obtain additional information, free of charge, about coverage or a specific benefit, particular contraceptive drug or any other aspect of benefits or requirements. If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the BAA will use reasonable medical management techniques to determine any coverage limitations.		

IV. PLAN EXCLUSIONS

Regardless of anything else stated in this document, the Preventive Care Program does not provide any benefits for:

(1) **Contraception** except as specifically described in the Covered Preventive Care Services Section of this document.

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments are not covered. Abortifacient drugs are not covered.

(2) **Educational or vocational testing.** Services for educational or vocational testing or training.

(3) **Examinations.**

- Any health examinations:
  - required by a third party, including examinations and treatments required to obtain or maintain employment, or which an *employer* is required to provide under a labor agreement;
    required by any law of a government, securing insurance or school admissions, or professional or other licenses; and
  - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity.

(4) **Exercise programs.** Exercise programs for prevention, care or treatment of any condition.

(5) **Eye care.** Routine eye examinations, including refractions, lenses for the eyes and exams for their fitting; except as specified in the Covered Preventive Care Services section of this document.

(6) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails; except as specified in the Covered Preventive Care Services Section of this document.

(7) **Foreign travel.** Preventive Care Services received outside of the United States except for Employees and dependents who are United States citizens or permanent residents of the United States working outside of the United States on a temporary basis.

(8) **Government coverage.** Preventive Care Services furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(9) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as specified in the Covered Preventive Care Services Section of this document.

(10) **Home and mobility.** Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device.

(11) **Injury or Sickness.** Services which are for diagnosis, care and treatment of a suspected or identified Injury or Sickness.

(12) **Maintenance Care.**
Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a Physician's practice;
- Charges to have preferred access to a Physician's services such as boutique or concierge Physician practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service; or
  - Care while in the custody of a governmental authority.

(13) **Medicare.** Payment for that portion of the charge for which Medicare or another party is the primary payer.

(14) **No charge.** Preventive Care for which there would not have been a charge if no coverage had been in force.

(15) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(16) **No Physician recommendation.** Preventive Care not recommended and approved by a Physician.

(17) **Out-of-Network Providers.** Preventive Care Services rendered by an Out-of-Network Provider.

(18) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air- purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(19) **Prescription Drugs.** Charges for Prescription Drugs or devices except for specified Prescription Drugs or devices in the Covered Preventive Care Services section of this document.

(20) **Services before or after coverage.** Preventive Care for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(21) **Services Provided by a family member.**

Services provided by a spouse, domestic partner, Civil Union partner, parent, child, step-child, brother, sister, in-law or any household member.

(22) **Speech therapy** for treatment of delays in speech development.

(23) **Strength and performance:** Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance.

(24) **Therapies and tests:**

- Aromatherapy;
- Bio-feedback and bioenergetics therapy;
- Carbon dioxide therapy;
- Chelation therapy
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy;

- Hypnosis, and hypnotherapy;
- Lovaas therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

(25) **Voluntary Sterilization** for male Insured Persons.

(26) **Weight:** Except as specified in the Covered Preventive Care Services section of this document:

- Drug, service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions; including but not limited to:
  - Liposuction
  - Weight control/loss programs and other services and supplies (including prepared meals);
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
  - Counseling, coaching, training, hypnosis or other forms of therapy; and
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

V. ENDING YOUR COVERAGE

Except as otherwise provided in this SPD, *Your* coverage will terminate on the earliest of the following dates:

- The date the *Plan* or PCP is terminated;
- The date the *covered employee* retires;
- The date *your* eligibility under the *Plan* or PCP ends;
- The date *your* written request to cancel coverage is received; unless the *covered employee's* premium payments are paid on a pre-tax basis, as pre-tax premium payments can only cease when certain change in status events occur;
- When *you* do not make *your* required *contribution* for coverage under the *Plan*. Termination will be retroactive to the last day for which *your* required *contribution* has been timely received; or

- The date *you*, or someone acting on *your* behalf, have performed an act or practice that constitutes fraud or made an intentional misrepresentation (including an omission) of material fact under the terms of the *Plan*.

For a *covered dependent* child, coverage will terminate the on the last day of the month the child is no longer eligible as a *covered dependent*. If *your covered dependent* child is disabled, coverage will end the date the *covered dependent* child marries or is no longer disabled.

VI. LEAVES OF ABSENCE

A. Family and Medical Leave Act (FMLA). The Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor. During any leave taken under the Family and Medical Leave Act, the *employer* will maintain coverage under this Plan on the same conditions as coverage would have been provided if the *covered employee* had been continuously employed during the entire leave period. If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

B. The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Continuation of *Benefits*. *Covered employees* who are absent due to service in the uniformed services and/or their *covered dependents* may continue coverage pursuant to USERRA for up to 24 months after the date the *covered employee* is first absent due to uniformed service duty.

Eligibility. A *covered employee* is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

Covered dependents who have coverage under the *Plan* immediately prior to the date of the *covered employee's* covered absence are eligible to elect continuation under USERRA.

Upon the *covered employee's* return to work immediately following his/her leave under USERRA, no new *waiting periods* will apply.

Premium Payment. If continuation of *Plan* coverage is elected under USERRA, the *covered employee or covered dependent* is responsible for payment of the applicable cost of coverage. If the *covered employee* is absent for not longer than 31 calendar days, the cost will be the amount the *covered employee* would otherwise pay for coverage. For absences exceeding 31 calendar days, the cost may be up to 102% of the cost of coverage under the *Plan*. This includes the *covered employee's* share and any portion previously paid by the *employer*.

Duration of Coverage. Elected continuation coverage under USERRA will continue until the earlier of:

1. Twenty-four months, beginning the first day of absence from employment due to service in the uniformed services;
2. The day after the *covered employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service;
3. The early termination of USERRA continuation coverage due to the *covered employee's* court-martial or dishonorable discharge from the uniformed services; or
4. The date on which this *Plan* is terminated.

The continuation available under USERRA does not affect continuation available under "COBRA Continuation Coverage." *Covered employees* should contact their *employer* with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the *employer* of any changes in marital status or a change of address.

Return to Work Requirements. Under USERRA a *covered employee* is entitled to return to work following an honorable discharge as follows:

1. Less than 31 days service: By the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight-hour rest period.
2. Thirty-one to 180 days: The *covered employee* must apply for reemployment no later than 14 days after completion of military service.
3. One hundred and eighty-one days or more: The *covered employee* must apply for reemployment no later than 90 days after completion of military service.
4. Service-connected *injury* or *sickness*: Reporting or application deadlines are extended for up to two years for persons who are *hospitalized* or convalescing.

VII. COBRA CONTINUATION COVERAGE

The *covered employee*, his/her covered spouse and covered dependent children may continue coverage under the Plan when a qualifying event occurs. *You* may elect COBRA for yourself regardless of whether the *covered employee* or other eligible dependents in *your* family elect COBRA. A *covered employee* and a covered spouse may elect COBRA on behalf of each other and/or their covered dependent children. If a loss of coverage qualifying event occurs:

1. In certain cases, the *covered employee* may continue his/her coverage and may also continue coverage for his/her covered spouse, domestic partner and covered dependent children when coverage would normally end;

2. In certain cases, the covered spouse and covered dependent children may continue coverage when coverage would normally end. A domestic partner may not continue coverage except as a *dependent* of a *covered employee* at the option of the *covered employee*;

3. Coverage will be the same as that for other similar *covered persons*; and

4. Continuation coverage under this *Plan* ends when this Plan terminates or as explained in detail on the following Continuation Chart. The *covered employee*, his/her covered spouse and covered dependent children may, however, be entitled to continuation coverage under another group health plan offered by the *employer*. *You* should contact the *employer* for details about other continuation coverage.

For general information about *your* rights and obligations under the *Plan* and/or federal COBRA law, you should contact the *employer*, which is the official *plan administrator*. For specific information pertaining to federal COBRA law and *your* rights and obligations under COBRA, *you* should contact the *Plan's* designated COBRA Administrator. For COBRA notice requirements and submission information refer to the appropriate portions of this section.

The Plan's designated COBRA Administrator is: Company

The *Plan's* designated COBRA Administrator may change from time to time. When that happens, you will be notified of the new COBRA Administrator.

Qualifying Events

1. Loss of coverage under this *Plan* by the *covered employee* due to one of these events:
   a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than "gross misconduct."
   b. Reduction in the hours of employment of the *covered employee*.
   c. Layoff of the *covered employee*.
   d. Leave of absence of the *covered employee*.
   e. Early retirement of the *covered employee*.

2. Loss of coverage under this *Plan* by the covered spouse and/or covered dependent children due to one of these events:
   a. Voluntary or involuntary termination of employment of the *covered employee* for reasons other than "gross misconduct."
   b. Reduction in the hours of employment of the *covered employee*.
   c. Layoff of the *covered employee*.
   d. Leave of absence of the *covered employee*.
   e. Early retirement of the *covered employee*.
   f. *Covered employee* becoming entitled to Medicare.
   g. Divorce or legal separation of the *covered employee*.
   h. Death of the *covered employee*.
3. Loss of coverage under this *Plan* by the covered dependent child due to his/her loss of "dependent child" status under this Plan.

4. Loss of coverage under this *Plan* due to the bankruptcy of the *employer* under Title XI of the United States Code. For purposes of this qualifying event (bankruptcy), a loss of coverage includes a substantial elimination of coverage that occurs within one year before or after commencement of the bankruptcy proceeding.

Required Procedures

When the initial qualifying event is death, termination of employment or reduction in hours (including leave of absence, layoff, or retirement), or Medicare entitlement of the *covered employee*, or the bankruptcy of the *employer*, the *plan administrator* will offer continuation coverage to qualified *covered persons*. *You* do not need to notify the *Plan Administrator* of these qualifying events. However, for other qualifying events including divorce or legal separation of the *covered employee* and loss of dependent child status, COBRA continuation is not available to *you* if *you* do not provide timely, written notice to the *plan administrator* as required below by the *Plan*. *You* must also provide timely, written notice to the designated COBRA Administrator of other events, such as a Social Security disability determination or second qualifying events, in order to be eligible for an extension of COBRA continuation as required by the *plan* as stated in this section. To elect COBRA, *you* must make a timely, written election as required by the *Plan* as stated in this section.

What the *plan administrator* must do:

1. Provide initial general COBRA notices as required by law;
2. Determine if the *covered person* is eligible to continue coverage according to applicable laws;
3. Notify persons of the unavailability of COBRA continuation;
4. Notify the *covered person* of his/her rights to continue coverage provided that all required notice and notification procedures have been followed by the *covered employee*, covered spouse and/or covered dependent children;
5. Inform the *covered person* of the premium *contribution* required to continue coverage and how to pay the premium *contribution*; and
6. Notify the covered person when he or she is no longer entitled to COBRA or when his/her COBRA continuation is ending before expiration of the maximum (18, 29, 36 month) continuation period.

What You must do:

1. *You* must notify the *plan administrator* in writing of a divorce or legal separation within 60 calendar days after either the date of the qualifying event, or the earliest date coverage would end due to the qualifying event, whichever is later;

2. *You* must notify the *plan administrator* in writing of a covered dependent child ceasing to be eligible within 60 calendar days after either the date of the qualifying event, or the earliest date coverage would end due to the qualifying event, whichever is later;

3. *You* must submit *your* written notice of a qualifying event within the 60-day timeframe, as explained previously in paragraphs 1 and 2, using the *Plan's* approved notice form. (*You* may obtain a copy of the approved form from the *plan administrator*.) This notice must be submitted to the *plan administrator* in writing and must include the following:

    - The name of the *plan*;
    - The name and address of the *covered employee* or former *covered employee*;
    - The names and addresses of all applicable dependents;
    - The description and date of the qualifying event;
    - Requested documentation pertaining to the qualifying event such as: decree of divorce or legal separation; and

- The name, address and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, or his/her dependent(s); or a representative acting on behalf of the employee or dependent(s).

All written notices as described previously in paragraphs 1, 2, and 3, under "What *You* must do" must be timely sent to the *plan administrator* at the address indicated in the section of this *SPD* entitled "Specific Information About *Your Plan*."

You must follow the *Plan's* procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this *SPD*, unless a different procedure is expressly required by the *employer* or its COBRA administrator.

4. To elect continuation, *you* must notify the designated COBRA Administrator of *your* election in writing within 60 calendar days after the date the *covered person's* coverage ends, or the date the *covered person* is notified of continuation rights, whichever is later. To elect continuation, *you* must complete and submit *your* written election within the 60-day timeframe using the *Plan's* approved election form. (*You* may obtain a copy of the approved form from the designated COBRA Administrator.) This election must be submitted to the designated COBRA Administrator in writing at the address as described in this section; and

5. *You* must pay continuation premium *contribution*:

    a. The premium *contribution* to continue coverage is the combined *employer* plus *covered employee* rate charged under the Plan, plus the *employer* may charge an additional two percent of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan's* total cost of coverage. The continuation election form will set forth *your* continuation premium *contribution* rate(s).

    b. The first premium *contribution* must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the *covered person's* monthly payments are due and payable by check at the beginning of each month for which coverage is continued.

    c. The *covered person* must pay subsequent premium *contributions* by check on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

What *You* must do to apply for COBRA extension:

A. Social Security Disability:

1. If *you* are currently enrolled in COBRA continuation under this *Plan*, and it is determined that *you* are totally disabled by the Social Security Administration within the first 60 calendar days of *your* current COBRA coverage, then *you* may request an extension of coverage provided that *your* current COBRA coverage resulted from the *covered employee*'s leave of absence, retirement, reduction in hours, layoff, or his/her termination of employment for reasons other than gross misconduct. To request an extension of COBRA, *you* must notify the designated COBRA Administrator in writing of the Social Security Administration's determination within 60 calendar days after the latest of:

    - The date of the Social Security Administration's disability determination;
    - The date of the *covered employee*'s termination of employment, reduction of hours, leave of absence, retirement, or layoff; or
    - The date on which *you* would lose coverage under the *Plan* as a result of the *covered employee*'s termination, reduction of hours, leave of absence, retirement, or layoff.

2. *You* must submit *your* written notice of total disability within the 60-day timeframe, as described previously in paragraph 1, and before the end of the 18th month of *your* initial COBRA coverage using the *Plan's* approved disability notice form. (*You* may obtain a copy of the approved form from the designated COBRA Administrator.) This notice must be submitted, in writing, to the designated COBRA Administrator and must include the following:

    - The name of the *Plan*;
    - The name and address of the *covered employee* or former *covered employee*;
    - The names and addresses of all applicable dependents currently on COBRA;
    - The description and date of the initial qualifying event that started *your* COBRA coverage;
    - The name of the disabled *covered person*;
    - The date the *covered person* became disabled;
    - The date the Social Security Administration made its determination of disability;
    - Requested copy of the Social Security Administration's determination of disability; and
    - The name, address and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, or his/her dependent(s); or a representative acting on behalf of the employee or dependent(s).

You must follow the *Plan's* procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this *SPD*, unless a different procedure is expressly required by the *employer* or its COBRA administrator. All written notices required for COBRA for a Social Security disability extension must be timely sent to the designated COBRA Administrator at the following address:

Company
HR Department
111 Main Street
City, State, XXXXX

3. To elect an extension of COBRA, *you* must notify the designated COBRA Administrator of the Social Security Administration's determination, in writing, within the 60 calendar day and the initial 18-month continuation period timeframes, by following the notification procedure as previously explained in paragraphs 1 and 2, and submitting the *Plan's* approved form; and

4. *You* must pay continuation premium *contributions*:

   a. The premium *contribution* to continue coverage is the combined *employer* plus *covered employee* rate charged under the *Plan*, plus the *employer* may charge an additional two percent of that rate. For a *covered person* receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months may be increased to 150% of the *Plan's* total cost of coverage. The disability notice form will set forth *your* continuation premium *contribution* rate(s).

   b. The first premium *contribution* must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the covered person's monthly payments are due and payable by check at the beginning of each month for which coverage is continued.

   c. The *covered person* must pay subsequent premium *contributions* by check on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the *Plan*.

B. Second Qualifying Events for Covered Dependents Only:

1. If *you* are currently enrolled in COBRA continuation under this Plan and the *covered employee* dies, or in the case of divorce or a legal separation of the *covered employee*, or a covered dependent child loses eligibility, then *you* may request an extension of coverage provided that *your* current COBRA coverage resulted from the *covered employee*'s leave of absence, retirement, reduction in hours, layoff or his/her termination of employment for reasons other than gross misconduct or resulted from a Social Security Administration disability determination. To request an extension of COBRA, *you* must notify the designated COBRA Administrator in writing within 60 calendar days after the later of:

   - The date of the second qualifying event (death, divorce, legal separation, loss of dependent child status); or
   - The date on which the covered dependent(s) would lose coverage as a result of the second qualifying event.

Note: This extension is only available to a covered spouse and covered dependent children. This extension is not available when a *covered employee* becomes entitled to Medicare.

2. *You* must submit *your* written notice of a second qualifying event within the 60-day timeframe, as previously described in paragraph 1, using the Plan's approved second event notice form. (*You* may obtain a copy of the approved form from the designated COBRA Administrator.) This notice must be submitted to the designated COBRA Administrator in writing and must include the following:

   - The name of the Plan;
   - The name and address of the *covered employee* or former *covered employee*;
   - The names and addresses of all applicable dependents currently on COBRA;
   - The description and date of the initial qualifying event that started *your* COBRA coverage;
   - The description and date of the second qualifying event;
   - Requested documentation pertaining to the second qualifying event such as: a decree of divorce or legal separation or death certificate; and
   - The name, address and telephone number of the individual submitting the notice. This individual can be a *covered employee*, former *covered employee*, or his/her dependent(s); or a representative acting on behalf of the employee or dependent(s).

You must follow the Plan's procedures for providing written notice, within the specified time period, and for timely submitting, in writing, all required information and supporting documentation as described in this SPD, unless a different procedure is expressly required by the *employer* or its COBRA administrator. All written notices required for COBRA for a second qualifying event extension must be timely sent to the designated COBRA Administrator at the following address:

Company
HR Department
111 Main Street
City, State xxxxx

3. To elect an extension of COBRA, *you* must notify the designated COBRA Administrator of the second qualifying event in writing within the 60 calendar day timeframe, by following the notification procedure as previously explained in paragraphs 1 and 2, and submitting the Plan's approved form; and

4. *You* must pay continuation premium *contributions*:

   a. The premium *contribution* to continue coverage is the combined *employer* plus *covered employee* rate charged under the Plan, plus the *employer* may charge an additional two percent of that rate. For a covered person receiving an additional 11 months of coverage after the initial 18 months due to a COBRA extension for Social Security disability, the premium *contribution* for those additional months

may be increased to 150% of the Plan's total cost of coverage. The election form will set forth *your* continuation premium *contribution* rates.

b. The first premium *contribution* must be paid by check within 45 calendar days after electing to continue the coverage. Thereafter, the covered person's monthly payments are due and payable by check at the beginning of each month for which coverage is continued.

c. The covered person must pay subsequent premium *contribution*s by check on or before the required due date, plus the 30 calendar day grace period required by law or such longer period allowed by the Plan.

Additional Notices *You* Must Provide: Other Coverages, Medicare Entitlement and Cessation of Disability

You must also provide written notice of (1) *your* other group coverage that begins after COBRA is elected under the Plan; (2) *your* Medicare entitlement (Part A, Part B or both parts) that begins after COBRA is elected under the Plan; and (3) the covered person, whose disability resulted in a COBRA extension due to disability, being determined to be no longer disabled by the Social Security Administration.

Your written notice for the events previously described in this section must be submitted using the Plan's approved notification form within 30 calendar days of the events requiring additional notices as previously described. The notification form can be obtained from the designated COBRA Administrator and must be completed by *you* and timely submitted to the designated COBRA Administrator at the address as described in this section. In addition to providing all required information requested on the Plan's approved notification form, *your* written notice must also include the following:

- If providing notification of other coverage that began after COBRA was elected, the name of the covered person
- who obtained other coverage, and the date that other coverage became effective.
- If providing notification of Medicare entitlement, the name and address of the covered person that became entitled to Medicare and the date of the Medicare entitlement.
- If providing notification of cessation of disability, the name and address of the formerly disabled covered person, the date that the Social Security Administration determined that he/she was no longer disabled and a copy of the Social Security Administration's determination.

CONTINUATION CHART

If coverage under this Plan is lost because this happens…	Who is eligible to continue…	Coverage may be continued until the earliest of: Coverage may be continued until the earliest of:

		a) the date coverage would otherwise end under the Plan; or b) the date the earliest of the following applicable events occurs:
The *covered employee*'s leave of absence, early retirement, hours were reduced, layoff, or his/her employment with the *employer* ended for reasons other than gross misconduct. Death of the *covered employee*.	*Covered employee*, covered spouse and covered dependent children	• 18 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the Plan. • Entitlement, after COBRA is elected under the Plan, of the applicable covered person to either Part A or Part B or both Parts of Medicare.
Divorce or legal separation from the *covered employee*. Entitlement of the *covered employee* to Medicare within 18 months before the *covered employee*'s hours were reduced or termination of employment for reasons other than gross misconduct. Covered person must provide timely notice of such event in accordance with the Plan's notice procedures	Covered spouse and covered dependent children	• 36 months after continuation coverage began. • 36 months after entitlement of *covered employee* to Medicare but only for an event which is the *covered employee*'s Medicare entitlement within 18 months before his/her hours were reduced or termination of employment. • Coverage begins under another group health plan after COBRA is elected under the Plan. • Entitlement, after COBRA is elected under the Plan, of the applicable covered person to either Part A or Part B or both Parts of Medicare.
Loss of eligibility by a covered dependent child. Covered person must provide timely notice of such event in accordance with the Plan's	Covered dependent child	• 36 months after continuation coverage began. • Coverage begins under another group health plan after COBRA is elected under the Plan.

notice procedures previously described for such events.		• Entitlement, after COBRA is elected under the Plan, of the applicable covered person to either Part A or Part B or both Parts of Medicare.
The *covered employee*, covered spouse or covered dependent child is determined by the Social Security Administration to be totally disabled within the first 60 calendar days of COBRA continuation coverage that resulted from the *covered employee*'s leave of absence, early retirement, reduction in hours, layoff, or his/her termination of employment with the *employer* for reasons other than gross misconduct. Timely notice of such disability must be provided by the covered person in accordance with the Plan's notice procedures previously described for COBRA extensions due to Social Security disability.	*Covered employee*, covered spouse and covered dependent children	• 29 months after continuation coverage began or until the first month that begins more than 30 calendar days after the date of any final determination that *covered employee*, covered spouse or covered dependent child is no longer disabled. • Coverage begins under another group health plan after COBRA is elected under the Plan. • Entitlement, after COBRA is elected under the Plan, of the applicable covered person to either Part A or Part B or both Parts of Medicare.

If *you* are a *covered employee*, covered spouse, or covered dependent who is enrolled in continuation coverage under this Plan due to a qualifying event (and not due to another enrollment event such as a special or annual enrollment), the Special Enrollment Period provisions of this SPD as referenced in the section which describes eligibility and enrollment will apply to *you* during the continuation period required by federal law as such provisions would apply to an active eligible *covered employee*. Eligible dependents that are newborn children or newly adopted children (as described in the eligibility and enrollment section) that are acquired by a *covered employee* during his/her continuation period required by federal law and are enrolled through special enrollment, are entitled to continue coverage for the maximum continuation period required by law.

If the continuation period required by federal law has been exhausted, and *you* are enrolled for additional continuation coverage pursuant to state law, if applicable, or the eligibility provisions of this plan, *you* may be entitled to the special enrollment rights upon acquisition of a new

dependent through marriage, birth, adoption, placement for adoption, or legal guardianship, as referenced in the section entitled Special Enrollment Period for New Dependents Only.

Special Rule for Persons Qualifying for Federal Trade Act Adjustments

The Federal Trade Act of 2002 gives special COBRA rights to *covered employee*s who terminate employment or experience a reduction of hours, and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under Federal Trade Act laws. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 calendar days (or less) and only during the six months immediately after their group health plan coverage ended.

If *you* qualify or may qualify for trade adjustment assistance under the Trade Act, contact the *plan administrator* for additional information. *You* must contact the *plan administrator* promptly after qualifying for trade adjustment assistance or *you* will lose *your* special COBRA rights.

Written Notices Required for COBRA Continuation

All notices, elections and information required to be furnished or submitted by a covered person, covered spouse or covered dependent children for purposes of COBRA continuation must be submitted in writing by U.S. mail or hand- delivery, or as previously described in this section. Oral communications, including phone calls, voice mails or in-person statements and electronic e-mail do not constitute written notice and are not acceptable for COBRA purposes under the Plan.

VIII. COORDINATION OF BENEFITS

As a covered person, *you* agree to permit the Plan to coordinate obligations under this SPD with payments under any other health benefit plans as specified below, which covers *you* as an employee or dependent. *You* also agree to provide any information or submit any claims to other health benefit plans necessary for this purpose. *You* agree to authorize billing to other health plans for purposes of coordination of benefits.

Unless applicable law prevents disclosure of the information without the consent of the covered person or the covered person's representative, each covered person claiming benefits under this Plan must provide any fact needed to pay the claim. If the information cannot be disclosed without consent, the Plan will not pay benefits until the information is given.

A. APPLICATION. This Coordination of Benefits provision applies when *you* have Preventive Care or other health care coverage under more than one plan. "Plan" is defined below.

B. DEFINITIONS. These definitions only apply to the Coordination of Benefits provision:

Allowable Expenses means a Preventive Care service or expense that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable

expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense.

Claim Determination Period means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Plan, or before the date this Coordination of Benefit provision or a similar provision takes effect.

Closed Panel Plan means a plan that provides health benefits to persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits or services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

Dependent means a *covered employee*'s eligible dependent as described in the section "Eligibility, Enrollment and Effective Date" who is enrolled under the Plan.

Plan means any of the following that provides benefits or services for preventive medical or dental care or treatment. However, if separate policies are used to provide coordinated coverage for members of any group, the separate policies are considered parts of the same plan and there is no Coordination of Benefits among these policies.

a. Group, blanket, franchise, closed panel or other forms of group or group type coverage (insured or uninsured);
b. Hospital indemnity benefits in excess of $200 per day;
c. Medical care components of group long-term care policies, such as skilled care;
d. A labor-management trustee plan or a union welfare plan;
e. An *employer* or multi-*employer* plan or employee benefit plan; f. Medicare or other governmental benefits, as permitted by law; g. Insurance required or provided by statute;
f. Medical benefits under group or individual automobile policies;
g. Individual or family insurance for hospital or medical treatment or expenses;
h. Closed panel or other individual coverage for hospital or medical treatment or expenses.

Plan does not include any:

i. Amounts of hospital indemnity insurance of $200 or less per day;
j. Benefits for non-medical components of group long-term care policies;
k. School accident-type coverages;
l. Medicare supplement policies;
m. Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage listed above is a separate plan. If a plan has two parts and Coordination of Benefits rules apply to one of the two, each of the parts is treated as a separate plan. The benefits provided by a plan include those that would have been provided if a claim had been duly made.

Primary Plan/Secondary Plan means the order of benefit determination rules which determine whether this Plan is a "primary plan" or "secondary plan" when compared to the other plan covering the person.

C. ORDER OF BENEFIT DETERMINATION RULES.

When this Plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this Plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

A plan that does not contain a Coordination of Benefits provision that is consistent with this section is always primary. Exception: Group coverage designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the *employer*.

A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

This Plan will not pay more than it would have paid had it been the primary plan. This Plan determines its order of benefits by using the first of the following that applies:

1. Nondependent/Dependent: The plan that covers the person other than a dependent, for example as an employee or subscriber is the primary plan; and the plan that covers the person as a dependent is the secondary plan.

   Exception: If the person is a Medicare beneficiary and federal law makes Medicare:

   a. Secondary to the plan covering the person as a dependent; and

   b. Primary to the plan covering the person as a nondependent (e.g., a retired employee); then the order is reversed, so the plan covering that person as a nondependent is secondary and the other plan is primary.

2. Child Covered Under More Than One Plan: The order of benefits when a child is covered by more than one plan is:

   a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or

- A court decree awards joint custody without specifying that one party has the responsibility to provide Preventive Care or other health care coverage.
- If both parents have the same birthday, the plan that covered either of the parents for a longer time is primary.

b. If the specific terms of a court decree state that one of the parents is responsible for the child's Preventive Care or other health care expenses or Preventive Care or other health care coverage and the plan of that parent has actual knowledge of those terms; then that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is the plan of the:

- Custodial parent;
- Spouse of the custodial parent;
- Noncustodial parent; and then
- Spouse of the noncustodial parent.

3. Active/Inactive Employee: The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary to a plan that covers the person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits. For example: coverage provided to a person as a retired worker and as a dependent of an actively working spouse will be determined under the rule in paragraph 1.

4. Continuation Coverage: If a person whose coverage is provided under a right of continuation provided by the federal or state law is also covered under another plan, then:
   a. The plan covering the person as an employee, covered person, subscriber (or as a dependent of an employee, covered person, subscriber) is the primary plan, except for pre-existing conditions under such plan.
   b. The continuation coverage is the secondary plan, except for pre-existing conditions excluded under the primary plan.
   c. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits; then this rule is ignored. This rule does not apply if the rule under paragraph 1 can determine the order of benefits.
5. Longer/Shorter Length of Coverage: The plan that covered the person as an employee or dependent for a longer time is primary.

D. THE EFFECT ON THE BENEFITS OF THIS PLAN. When this Plan is secondary, it may reduce its benefits, so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses.

E. RIGHT TO RECEIVE AND RELEASE INFORMATION. Certain facts about Preventive Care and other health care coverage and services are needed to apply Coordination of Benefit rules and to determine benefits payable under this Plan and other plans. The *third party*

administrator may get the facts it needs from or give them to any other organization or person for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The third party administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to apply those rules and determine benefits payable.

F. FACILITY OF PAYMENT. A payment made under another plan may have included an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under this Plan. The Plan will not pay that amount again. The term "payment made" includes providing benefits in the form of services. In this case "payment made" means the reasonable cash value of the benefits provided in the form of services.

G. RIGHT OF RECOVERY. If the Plan paid more than it should have paid, it may recover the excess from one or more of the following:

1. The persons the Plan has paid or for whom it has paid; or
2. Any other person or organization that may be responsible for the benefits or services provided under this Plan to the covered person.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

H. COORDINATING WITH MEDICARE. This section describes the method of payment if Medicare pays as the primary plan.

If a provider has accepted assignment of Medicare, this Plan determines allowable expenses based upon the amount allowed by Medicare. This Plan's allowable expenses are the lesser of the usual and customary amount or the Medicare allowable amount. The Plan pays the difference between what Medicare pays and the Plan's allowable expenses.

If *you* are eligible for Medicare, *you* will be considered covered for benefits payable under Medicare Part B regardless of whether *you* have applied for Medicare Part B coverage.

IX. HOW TO SUBMIT A BILL IF YOU RECEIVE ONE FOR COVERED SERVICES

A. Bills from Participating Providers

When *you* present *your* identification card at the time of requesting services from participating providers, paperwork and submission of post-service claims relating to services will be handled for *you* by *your* participating provider. *You* may be asked by *your* provider to sign a form allowing *your* provider to submit claims on *your* behalf. If *you* receive an invoice or bill from *your* provider for services, simply return the bill or invoice to *your* provider, noting *your* enrollment in the Plan. *Your* provider will then submit the post-service claim under the Plan in accordance with the terms of its participation agreement.

Your claim will be processed for payment according to the *employer's* coverage guidelines. The *third party administrator* must receive claims within 365 calendar days after the date services

were incurred, except in the absence of *your* legal capacity. Claims received after the deadline will be denied.

B. Bills from Non-Participating Providers

Payment of Claims. Claims submitted by Non-Participating Providers will not be covered under this plan.

X. IF YOU HAVE A COMPLAINT

If the complaint involves issues relating to quality of Preventive Care rendered by a participating provider, *you* should also attempt to discuss the quality of care issues with the provider. *You* may also direct any questions or complaints to Customer Service. When Customer Service is contacted, the representative will assist *you* in trying to resolve the complaint with the provider on an informal basis. The representative will also document the complaint. If these discussions are not satisfactory, *you* may submit a written complaint to the *plan administrator*. However, the *plan* is not responsible for the quality of care rendered by a participating provider.

XI. APPEALS

The Plan provides for two levels of appeal. When a claimant receives an adverse benefit determination, the claimant has 90 days following the original adverse determination in which to file in writing a First Level Appeal of the decision. Requests for appeals received after such ninety (90) calendar day period will not be eligible for review under the Plan. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

First Level Appeal

Appropriate staff of the *Third Party Administrator* will review the Covered Person's First Level Appeal. The Covered Person will be notified of the appeal decision in writing within thirty (30) calendar days after receipt of the appeal. If the resolution is satisfactory to the Covered Person, the matter ends. The *third party administrator* may consult with the *plan administrator* on First Level Appeals.

Second Level Appeal

If the First Level Appeal resolution is not satisfactory, the Covered Person may submit a written Second Level Appeal within thirty (30) days of receipt of the First Level Appeal decision. The Second Level Appeal may be submitted to the *third party administrator* or directly to the *plan administrator*. *You* may submit any new or additional information that *You* would like the *plan administrator* to consider during the Second Level Appeal review. The *plan administrator* will make a determination within thirty (30) calendar days after receiving *Your* request.

XII. DEFINITIONS OF TERMS USED

Benefits: The Preventive Care services or supplies covered under the Preventive Care Program as approved by the *plan administrator* as covered services, as explained in this SPD and any amendments.

Claim: A request for benefits made by a covered person or his/her authorized representative in accordance with the procedures described in this SPD.

Contribution: The payment *your employer* requires to be paid on behalf of or for covered persons for the provision of covered services. *Your employer* will inform *you* of *your* share of the *contribution.*

Covered Dependent: A *covered employee*'s eligible dependent as described in the section "Eligibility, Enrollment and Effective Date" who is enrolled under the Plan.

Covered employee: The person:
1. On whose behalf *contribution* is paid; and
2. Whose employment is the basis for membership; and
3. Who is enrolled under the Plan.

Covered Person: A *covered employee* or *covered dependent*.

Covered Services: Preventive Care services that are provided by *your* provider or clinic and are covered by the Plan, subject to all of the terms, conditions, limitations and exclusions of the Plan.

Effective Date: The date *you* become eligible for Preventive Care services and complete all enrollment requirements, subject to any required waiting period.

Eligible Charges: A charge for Preventive Care services and supplies, subject to all of the terms, conditions, limitations and exclusions of the Plan for which the Plan or covered person will pay.

Employer: The Company.

ERISA: The Employee Retirement Income Security Act of 1974 and the implementing regulations, as amended from time to time.

Incurred: Services and supplies rendered to *you*. Such expenses shall be considered to have been incurred at the time or date the service or supply was actually purchased or provided.

Injury: Bodily damage other than sickness including all related conditions and recurrent symptoms. Injury is not covered by this Plan.

Named Fiduciary: The *plan administrator*. The fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan.

Non-Participating Provider: A provider not under contract as a participating provider.

Participating Provider: A licensed clinic, physician, provider or facility that is directly contracted to participate in the specific Plan participating provider network designated by *plan*

administrator to provide benefits to covered persons enrolled in this Plan. The participating status of providers may change from time to time.

Physician: A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), or Doctor of Chiropractic (D.C.).

Plan: The Company Comprehensive Health and Welfare Plan, as amended from time to time. The PCP described in this document is a component of the Plan.

Plan Administrator: Your *Employer*, as defined under Section 3(16) of ERISA, that has the exclusive, final and binding discretionary authority to administer the *plan*, to make factual determinations, to construe and interpret the terms of the this SPD, *plan*, and amendments (including ambiguous terms), and to interpret, review and determine the availability or denial of benefits.

Plan Sponsor: Company, which is the entity that establishes and maintains the Plan and PCP, has the authority to amend and/or terminate the *plan* or PCP and is responsible for providing funds for the payment of benefits.

Plan Year: The period following the effective date of the *plan* and each subsequent 12-month period this *plan* remains in force.

Preventive Care: See Article III above.

Provider: A Preventive Care professional or facility licensed, certified, or otherwise qualified under state law to provide Preventive Care services.

Sickness: A bodily disorder, disease, physical sickness or mental disorder. Sickness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy. Sickness is not covered by this Plan.

Third Party Administrator: Bay Bridge Administrators provides administrative services to the *employer* limited to processing of claims.

Waiting Period: The period of time that an eligible individual must wait before becoming effective under the Plan. The Waiting Period will not be longer than 60 days from the *covered employee*'s date of employment to the first day of coverage under the Plan.

***YOU/YOUR*: REFERS TO *COVERED EMPLOYEE, COVERED DEPENDENT* OR *COVERED PERSON*.**

XIII. STATEMENT OF ERISA RIGHTS

AS A PARTICIPANT IN THIS PLAN, YOU ARE ENTITLED TO CERTAIN RIGHTS AND PROTECTIONS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA). ERISA PROVIDES THAT ALL PLAN MEMBERS SHALL BE ENTITLED TO:

Receive Information About Your Plan and Benefits

Examine, without charge, at the *plan administrator's* office and at other specified locations, such as worksites and union halls, all documents governing the plan, including health benefit contracts and collective bargaining agreements, and a copy of the latest annual report (form 5500 series) filed by the company with the U.S. Department of Labor and available at the public disclosure room of the pension and welfare benefits administration.

Obtain, upon written request to the *plan administrator*, copies of documents governing the operation of the plan, including health benefits contracts and collective bargaining agreements, and copies of the latest annual report (form 5500 series) and updated summary plan description. The *plan administrator* may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The *plan administrator* is required by law to furnish each member with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your cobra continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan members, ERISA imposes duties upon the *plan administrator* who is responsible for the operation of the employee benefit plan. The *plan administrator*, also called a fiduciary of the plan, has a duty to do so prudently and in the interest of you and other plan members and beneficiaries. No one, including your *employer*, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the *plan administrator* to provide the material and pay you *up to $110 a day* until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part,

you may file suit in a state or federal court. *In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.* If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

IF YOU HAVE ANY QUESTIONS ABOUT YOUR PLAN, YOU SHOULD CONTACT THE *PLAN ADMINISTRATOR*. IF YOU HAVE ANY QUESTIONS ABOUT THIS STATEMENT OR ABOUT YOUR RIGHTS UNDER ERISA, OR IF YOU NEED ASSISTANCE IN OBTAINING DOCUMENTS FROM THE *PLAN ADMINISTRATOR*, YOU SHOULD CONTACT THE NEAREST OFFICE OF THE PENSION AND WELFARE BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF LABOR, LISTED IN YOUR TELEPHONE DIRECTORY OF THE DIVISION OF TECHNICAL ASSISTANCE AND INQUIRIES, PENSION AND WELFARE BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF LABOR, 200 CONSTITUTION AVENUE N.W., WASHINGTON, D.C. 20210. YOU MAY ALSO OBTAIN CERTAIN PUBLICATIONS ABOUT YOUR RIGHTS AND RESPONSIBILITIES UNDER ERISA BY CALLING THE PUBLICATIONS HOTLINE OF THE PENSION AND WELFARE BENEFITS ADMINISTRATION.

XIV. ERISA PLAN DESCRIPTION

Plan Name:	Company Comprehensive Health and Welfare Plan. This document describes the Preventive Care Program which is a component of the overall plan.
Plan Number:	xxx
Type of Plan:	Welfare benefit plan
Plan Year:	12-month period beginning January 1 and ending December 31
Plan Sponsor & *employer*:	Company 111 Main Street City, State xxxxx xxx-xxx-xxxx
Plan Sponsor Tax Identification Number:	xx-xxxxxxx
Participating Affiliates:	None

Plan Administrator and Named Fiduciary:	Company 111 Main Street City, State xxxxx xxx-xxx-xxxx
Sources of Contributions:	Employee contributions only.
Funding:	This Preventive Care Program is a self-insured arrangement; therefore the *employer* pays all claims from its general assets. Because it is not possible to know in advance exactly how much the claims and costs under the Preventive Care Program will be for a year, in some years, required *contributions* will be higher than the actual cost of Preventive Care Program coverage for the year. In that case, excess *contributions* will be applied according to the terms of the Company Comprehensive Health and Welfare Plan, but will not be returned to individuals who participate in the Preventive Care Program. *Your employer* will inform *you* of *your* required *contributions* for the Preventive Care Program.
Third Party Administrator:	Bay Bridge Administrators P.O. Box 161690 Austin, TX 78716 1-800-845-7519
Agent for Legal Process:	Service of legal process may be made upon the *plan administrator* at the address noted above.